Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	001148	A. BUILDING _____ B. WING _____	R-C 12/18/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOOD RIDGE ASSISTED LIVING	17650 GENERATIONS DR SOUTH BEND, IN 46635

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{R 000}	INITIAL COMMENTS This visit was for the Post Survey Revisit (PSR) to the Investigation of Complaint #IN00113492. Complaint #IN00113492 - corrected Survey date: December 18, 2012 Facility number: 001148 Provider number : N/A AIM number: N/A Survey team: Julie Wagoner, RN Census bed type: Residential: 65 Census payor type: Medicaid: 43 Other: 22 Total: 65 Residential sample: 05 Wood Ridge Assisted Living was found to be in compliance with 410 IAC 16.2 in regards to the PSR to the Investigation of Complaint #IN00113492. Quality Review completed on December 26,2012, by Brenda Meredith R.N.	{R 000}		